



An Independent Licensee
of the Blue Cross and
Blue Shield Association

Precertification Request Form for **Ampyra®**

Precertification for Ampyra® requires completion of this form in its entirety. All requested data must be provided. Once completed the form must be signed by the medical provider and faxed back to BCBSAZ Pharmacy Management at **(602) 864-3126**. Incomplete forms may result in denial of requested medication due to lack of needed information.

Provider Information				Patient Information		
Physician's Name				Patient's Name		
Physician Specialty		NPI #		BCBSAZ Member ID		
Mailing Address				Date of Birth / /		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
City	State	Zip Code		Patient's Address		
Phone # () - ext		Fax # () -		City	State	Zip Code

Medication Information	
Medication Name & Strength:	_____
Directions for Use & Duration:	_____
Diagnosis Code:	_____
Diagnosis:	_____

**All of the following questions and/or information must be answered and provided to assess request:
(Office notes are not needed if all information has been provided)**

Yes	No	
		Individual has Multiple Sclerosis (MS), is ambulatory, has reduced walking speed or significant limitations of instrumental activities of daily living attributable to slow ambulation (such as meal preparation, household chores, etc) and has a baseline timed 25 foot walking speed is between 8 to 60 seconds
		Individual has concurrent therapy with disease modifying treatment for MS as indicated (please indicate therapy): <input type="checkbox"/> Avonex <input type="checkbox"/> Betaseron <input type="checkbox"/> Copaxone <input type="checkbox"/> Extavia <input type="checkbox"/> Gilenya <input type="checkbox"/> Novantrone <input type="checkbox"/> Rebif <input type="checkbox"/> Tysabri
		Dosage will be limited to 10mg twice daily
		Creatinine clearance will be obtained routinely while on therapy to monitor contraindication for use

I have ruled out the following conditions and/or circumstances:

Yes	No	
		History of seizures or at high risk for seizures
		Moderate to severe renal impairment (a Creatinine clearance (CrCl) < 50 mL/min)
		Pregnancy or likely to become pregnant or breast feeding

The following data must be submitted for initial requests and/or for renewal/continuation of therapy:

Baseline timed 25 foot walking speed is/was: _____
Best follow-up timed 25 foot walking speed that shows at least a 20% improvement is/was: _____

Signature affirms that information given on this form is true and accurate and reflects office notes

Physician's Signature	Date
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